Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL CENTER ANESTHESILOGISTS PC
411 LAUREL SUITE 3170
DES MOINES IA 50314

Respondent Name
EMPLOYERS INSURANCE CO OF WAUSAU

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-3222-01

MFDR Date Received
JUNE 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated September 13, 2011: "We are appealing the denial of the attached claim. Prior authorization was obtained for the services. Please review claims with authorization numbers 1061860 & 1069336 indicated on the claims."

Requestor's Position Summary dated September 14, 2011: "According to documentation, UniMed Direct originally denied these services requesting additional records. Those records were obtained and a call was placed to Iowa Ortho on 03/18/2011 authorizing the services."

Requestor's Position Summary dated March 29, 2012: "We are requesting a second level appeal by the insurance carrier. Documentation shows attempts for prior authorization were made however contact was unsuccessful. Medical records fully support the treatment provided."

Amount in Dispute: $3,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This claim is not in the Liberty HCN. Please be advised that this claim/file was transferred to a new carrier in 2004. We are no longer the carrier and are not able to issue or reconsider any payments."

Response Submitted by: Liberty Mutual Insurance

Respondent's Position Summary: "The current dispute involves bilateral medial branch blocks performed on 3/25/11 in the sum of $3,200.00. As the attached indicates the request for pre-authorization (umd id 1061860) was denied in an URA report dated 02/28/11. The provider claims that it obtained pre-authorization for 106860[sic] but provides no evidence of this. In an amended and attached EOB, the carrier maintains its denial and claim that UMD ID 1061860 was not preauthorized. As a result, no reimbursement is due."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2011	CPT Code 64493-50	$1,440.00	$0.00
	CPT Code 64494-50	$800.00	$0.00
	CPT Code 64495-50	$800.00	$0.00
	CPT Code 99144	$160.00	$0.00
TOTAL		$3200.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 197-Precertification/authorization/notification absent.
   - 851-000-Payment denied/reduced for absence of precertification/authorization.
   - 901-Reconsideration no additional payment. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Was the request for dispute resolution timely filed?

Findings

1. The requestor provided services in the state of Iowa on March 25, 2011 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was not satisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.

2. 28 Texas Administrative Code § 133.307(c)(1)(A) states "Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (1) Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The date of the services in dispute is March 25, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 26, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed

to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

		06/12/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.